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House Bill_____
By
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Senate Bill No.SB0272
By Womack

AN ACT to amend Tennessee Code Annotated, Title 56, to enable certain entities to establish preferred provider arrangements and provide quality health, mental health, and substance abuse benefits while maintaining the costs of such benefits through the use and regulation of preferred provider arrangements.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The title of this act is and may be cited as “The Preferred Provider Organizations Act of 1995" hereinafter "the act".

SECTION 2. The general assembly hereby finds and declares that the purposes of this act are to:

(A) Promote the delivery of quality health care, mental health care, and substance abuse services;

(B) Promote the delivery of health care, mental health care, and substance abuse benefits in a cost effective manner;

(C) Encourage preferred provider arrangements;

(D) Protect insureds by establishing minimum benefits to be provided by preferred provider organizations; and

(E) Protect the public by authorizing the commissioner of commerce and insurance to develop and promulgate regulations pursuant to this Act to regulate those preferred provider arrangements.

SECTION 3. For purposes of this act, unless the context otherwise requires:

(1) "Commissioner" means the commissioner of commerce and insurance.

(2) "Health care services" includes medical care, hospital care, home health care, nursing home care, mental health care, and substance abuse services including all acts of diagnosis, treatment, evaluation or advice or such other acts as may be permissible under the health care licensing statutes of this state.

(3) "Health care provider" means any person who or entity which holds a license under the laws of this state and may, within the scope of such license, perform or provide any health care service authorized under the laws of this state and covered in an insurance policy.

(4) "Preferred provider organization", hereinafter "PPO" or "preferred provider arrangement", means a health care financing and delivery program whereby insureds receive financial incentives to utilize services rendered by health care providers who have contracted with the PPO.

(5) "Preferred provider" means any health care provider who has entered into a contract with a PPO.

(6) "Nonpreferred provider" means any health care provider who is eligible for payment under a preferred provider arrangement, but has not entered into a contract with a PPO.

(7) "Utilization review" is a mechanism for prospective and concurrent review aimed at reviewing the efficient allocation of health care, mental health care, and substance abuse services to be given to a patient or group of patients, which mechanism is to be used in the best interests of the patient.

SECTION 4. Not later than one (1) year after the effective date of this act, the commissioner shall promulgate and adopt regulations establishing:

(1) Procedures to ensure the accessibility of provider services to individuals comprising the insured or contractual group.

(2) The adequacy of number of health care providers and license classifications of such providers.

(3) The adequacy of number and locations of institutional facilities and health care providers therein.

(4) Procedures to ensure that the policy or contract is consistent with the standards of good health care.

(5) Procedures to ensure that all contracts with insureds, health care providers, and institutional facilities are fair and reasonable.

(6) Procedures to ensure that preferred and nonpreferred providers are reimbursed in a prompt and efficient manner.

(7) Procedures to ensure that utilization review and any cost containment procedures are performed in a fair and equitable manner.

(8) Procedures to ensure that grievance procedures are efficient, fair, and equitable.

SECTION 5. Notwithstanding any conflicting provisions of this act, a PPO regulated by this act must comply with all applicable insurance and other laws of the state as determined by the commissioner.

SECTION 6. Any health care insurer or third party administrator may offer a PPO to insureds. Such PPO shall contain at least the following provisions:

(1) Every PPO regulated by this act shall provide coverage for health care services in the same manner as required for policies of insurance by Title 56, Chapter 7, Part 24.

(2) Every PPO regulated by this act shall provide insureds with the right to exercise full freedom of choice in the selection of hospital or health care provider. Differences in benefit levels between preferred and nonpreferred providers shall not unfairly deny the insured of such freedom of choice.

(3)

(A) A PPO shall not discriminate against any class of health care provider who is licensed and qualified to provide the health care services designated in the insurance policy.

(B) A PPO shall not discriminate against any provider on the basis of race, religion, national origin, disability, color, age, sex, marital status, or such provider's relationship with any other organization. Such discrimination shall be subject to relevant laws and penalties.

(4) A PPO shall reimburse insureds for emergency care services rendered by nonpreferred providers at the same benefit level as if services had been rendered by preferred providers.

(5)

(A) An exclusive provider arrangement, which, as a condition of coverage, requires insureds to obtain services exclusively from health care providers who have entered into such arrangements, shall be prohibited.

(B) Differences in co-payment and deductible levels between preferred and nonpreferred providers shall be no greater than necessary to provide a reasonable incentive for insureds to utilize the services of preferred providers and shall not exceed fifteen percent (15%) of the rate paid for the service rendered.

(6) No financial incentive or withhold arrangement shall exist for a preferred or nonpreferred health care provider. A PPO contract must include a certification that

there is no financial incentive that could influence a utilization review determination by a panel member. The plan must include a statement of the identification of every person and entity, no matter how organized, which has a financial interest in the PPO and amount and nature of the financial interest.

(7)

(A) A PPO shall disclose at least the following to insureds in a written document:

(i) A list of preferred providers, their specialties, and their locations;

(ii) The extent of coverage, limitations, and exclusions of health care services under the PPO; and

(iii) The incentives for the insured to use a preferred provider as well as the method of reimbursement for services provided by a nonpreferred provider.

(B) A PPO shall not make reference to the quality, cost, or availability of nonpreferred providers.

(C) A PPO shall provide insureds with a clear description of the grievance procedure to be followed in the case of complaints with preferred providers, the PPO, or other persons associated with the PPO.

(8) A PPO shall ensure that the confidential relationship between the health care provider and the patient is safeguarded pursuant to state and federal law. Information pertaining to the diagnosis, treatment, or health of any person receiving health care benefits shall be confidential and shall not be disclosed to any person, except to the extent that it may be necessary to carry out the purposes for this act. All information released to the PPO administrator shall require prior patient authorization. In those instances in which a patient desires to further protect the confidentiality of mental

health records otherwise privileged, such patient shall be allowed to invoke an option whereby the treating provider can submit only the identification of the patient and the appropriate diagnostic classification. If a patient chooses this, option the PPO may reduce the reimbursement rate by not more than fifteen percent (15%) of the usual and customary fee paid to similarly credentialed providers of care and/or allow the patient to exchange inpatient days of coverage for outpatient days of coverage at a rate of one (1) inpatient day for four (4) outpatient days. Selection of this option by a patient shall not result in any detrimental action by the PPO to either the provider or the patient. PPO's shall be required to notify patients of the availability of this option.

(9) A PPO shall provide for utilization review of health care, mental health care, and substance abuse care services. Such review shall only be conducted by health care providers who are trained in the same area of practice for which the review is being conducted. Such review shall take into consideration quality of care, performance of preferred providers, and cost efficiency. A PPO shall comply with all applicable laws of this state with respect to its utilization review activities.

(10) A PPO shall not be permitted to terminate a contract with a provider on less than sixty (60) days prior written notice.

SECTION 7.

(a) A PPO shall register with the commissioner and certify that it has complied with all of the provisions of this act. The commissioner may extend the deadline for compliance with the provisions of this act if the commissioner determines it is in the best interests of insureds and providers.

(b) A PPO shall file with the commissioner a copy of all standard form provider contracts, insured contracts, other contracts as the commissioner deems necessary, and all enrollee literature used by the PPO.

(c) A PPO shall file an annual report with the commissioner, which shall at least include the following:

(1) Certification that it is complying with all applicable statutory and regulatory provisions;

(2) The number of persons who are receiving health care, mental health care, and substance abuse care benefits;

(3) The number of individuals and groups who have contracted with the PPO;

(4) The number of preferred providers and their specialties; and

(5) The dollar volume of business conducted by the PPO.

SECTION 8.

(a) Whenever the commissioner has reason to believe that a PPO subject to this part has been or is engaged in conduct that violates this part, the commissioner shall notify the PPO of the alleged violation. The PPO shall have thirty (30) days from the date the notice is received to respond to the alleged violation.

(b) If the commissioner believes the PPO has violated this part, or is not satisfied that the alleged violation has been corrected, the commissioner may conduct a contested case hearing on the alleged violation in accordance with the Administrative Procedures Act, compiled in title 4, chapter 5.

(c) If, after conducting such hearing, the commissioner determines that the PPO has engaged in violations of this part, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the PPO a copy of the findings and an order requiring the PPO to cease and desist from engaging in the violations. The commissioner may also, at the commissioner's discretion, order:

(1) Payment of a penalty of not more than ten thousand dollars ($10,000) in the aggregate for a violation that has occurred with such frequency as to indicate a general business pattern or practice; or

(2) Suspension or revocation of the authority to do business in this state as a PPO if the PPO knew the act was in violation of this part and repeated the act with such frequency as to indicate a general business pattern or practice.

(d) In addition to any other kind of punishment set forth in this act, a PPO or its agents who violates any provision of this act or any regulation adopted under this act or who submits any false information in an application required by this act is guilty of a misdemeanor and on conviction is subject to a fine of no more than five thousand dollars ($5,000) for each violation, except that total fines shall not exceed fifty thousand dollars ($50,000).

SECTION 9. This act shall take effect upon becoming law, the public welfare requiring it.

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